STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. BUILDING 00 B. WING	05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure survey. This visit included a State Residential Licensure survey. Survey dates: May 12, 13, 14, 15, and 16, 2014 Facility number: 000548 Provider number: 155472 AIM number: N/A Survey Team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Gloria Bond, R.N. Sandra Nolder, R.N. Census bed type: SNF--11 NCC--51 Residential--140 Total--202 Census payor type: Medicare--9 Other--193 Total--202 Residential Sample: 9 NCC sample: 6	F000000	This plan of correction constitutes the written compliance for the deficiencies cited. However, submission of this plan of correction is not an admittance that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on May 22, 2014.			
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to offer an alternative method of bathing for 1 of 1 residents who refused showers as a method of bathing. (Resident #15) Findings include: Resident #15's record was reviewed on 5/15/14 at 7:12 A.M. Diagnoses included, but were not limited to, vascular dementia, depression, and memory lapses or loss. A document titled "Social Service MDS [Minimum Data Set] Documentation" dated 5/5/14, indicated "...Resident's Attitude: Cooperative...BIMS [Brief	F000242	1.Resident #15 was admitted to the rehab unit in the Health Center on 4/8/14. As confirmed by the state surveyors, staff did interview the resident in regards to bathing choices on 4/24/14 and at that time resident had indicated he would like to take showers. Resident #15 was switched from assistance with showers to assistance with bed baths on 5/16/14 and was recently discharged to home with his wife on 5/24/14 after completing his rehab stay. 2.There were no other residents affected. 3.In an effort to ensure ongoing compliance, residents are interviewed about bathing preferences and those preferences are reflected in the residents' plan of care. CNA's are	06/14/2014

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	Interview of Mental Status]: Score: 9/15 Moderately Impaired...Delirium and Disorderly Thinking: Assessment: Res has not had any indicators of delirium or disorderly thinking this assessment period...Mental Status Change: No. Thought Content: WNL [Within Normal Limits]...Mood Evaluation:..Euthymic [even mood], Calm, Pleasant...Depression Scale: Type of Scale Used: PHQ-9. Date Given: 5/5/14. Score: 1, which indicates minimal depressive severity...Psychosis and Behavior Symptom Evaluation: Assessment: Res has not had any indicators of psychosis or behavior symptoms this assessment period. Physical Behavior Symptoms directed towards others: None. Verbal Behavior Symptoms directed towards others: None. Other Behavior Symptoms Not Directed Towards Others: None. Rejection of Care: None...." A document titled "My Choices for Care" dated 4/24/14, provided by the Director of Nursing on 5/16/14, indicated the resident's choice for bathing was a shower and the time of day he preferred to bathe/shower was Morning. A document titled "Medicare CNA Assignment" dated 5/15/14, used to communicate care of the resident to the		responsible for filling out a bathing/shower sheet each time they assist a resident with a shower or bath. The bathing/shower sheet has been updated to include alternatives offered as well as any behaviors exhibited during bathing (see attachment #A). A nurse will weekly review bathing sheets to ensure that staff are following residents plan of care for bathing preference. 4.As a means of quality assurance, the bathing/shower sheet audits will be reviewed with the Quality Assurance committee, quarterly, to ensure that residents' bathing preferences are being addressed.	

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	CNA indicated, the resident required one person physical assist with ADL's (Activities of Daily Living). A document titled "Daily skilled Nursing Assessment" document dated 4/28/14, indicated in the "Comment" section that at 4:30 P.M., the resident had received a shower in the A.M., and the CNA indicated, the resident was yelling out and combative during the shower. The CNA indicated, there was nothing "wrong" with him, he just yelled out and he continued to yell out until the shower was completed. The note had no documentation found to indicate the shower was stopped when the resident started yelling and an alternative means of bathing was offered to the resident. A document titled "Daily Skilled Nursing Assessment" dated 5/9/14 at 7:55 A.M., indicated in the "Comment" section that the resident had refused his shower on this A.M., after "multiple attempts". The staff indicated, when the resident was queried why he did not want to take a shower, he had indicated, "Because I want to stink." After the staff explained to the resident that he could go one time a week without taking a shower and inquired why he wanted to "stink" the resident indicated, "To keep everyone away."			

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A document titled "Nursing Assistant Skin Observation Report With Shower/Bath" dated 5/9/14, indicated the resident was asked to take a shower three times and he refused to take the shower.

A document titled "Daily Skilled Nursing Assessment" dated 5/13/14, indicated in the "Comment" section at 12:10 P.M., the resident was combative, attempted to hit the nursing staff and attempted to stand up off the shower chair and "almost fell to the floor." The resident yelled at the staff to keep the water off him because it was "hot." The note indicated, the shower water was cool to the touch at the time of the shower. The note had not indicated that the shower was stopped when the resident yelled at the staff to keep the water off him and became combative or that another form of bathing was attempted. The note indicated a "Behavioral Referral Form" was completed and sent to Social Services.

A document titled "Nursing Assistant Skin Observation Report With Shower/Bath" dated 5/13/14, indicated the resident was combative and calling out during the shower and he refused the shower.

A document titled "Behavior Health

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	Referral" dated 5/13/14, indicated "Describe the behavior or action: attempting to hit staff, hitting staff. yelling, cussing at staff. Location, Date and Time: 5/13/14. Duration (5 min, 30 min, 3 hours): 20-30 minutes, Intentional and Defensive What occurred prior: attempting to do care, shower, and accucheck. Environmental triggers: shower [water was to hot], CNA made sure water was cool to touch, still c/o [complains] being to hot. Temperature of room: warm...Was resident trying to communicate something: that he didn't want a shower Told staff on 5/9/14 when he refused shower he wanted to stink...." During an interview on 5/15/14 at 10:00 A.M., the resident indicated, he did not like to take showers and he would prefer to take a bed bath. He indicated he did not like to take a shower because it was to cold. He indicated he did tell the staff that he did not want to take his showers when they took him into the shower room. During an interview on 5/15/14 at 11:51 A.M., CNA #1 indicated, the resident just recently started refusing his showers and when he refused his showers for her, she washed him up. She indicated the resident had not refused a sponge bath. She indicated she had attempted to give			

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	him a shower today and he refused times three when she took him into the shower room and attempted to get him to allow her to shower him. She notified her charge nurse. She indicated she had already given him a sponge bath when she got him up this A.M. She indicated she had not been told she was not to give this resident a shower because he had been refusing them. She did not know the resident was combative and "almost fell out of the shower chair" when staff members attempted to shower him on 5/13/14. During an interview on 5/15/14 at 4:40 P.M., the Administrator and DoN indicated if a resident became combative, started to yell or refused a shower after it was started the staff were to stop the shower and attempt an alternative way to bathe the resident. The DoN indicated the CNA's have been inserviced on bathing residents and they were shown the video "Bathing without a Battle" as an instruction tool for bathing residents without the resident being combative. During an interview on 5/16/14 at 10:10 A.M., LPN #2 indicated on 5/13/14, when the CNA attempted to give the resident his shower, he refused due to the water being "hot" and she attempted to adjust the water. When the CNA could			

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	not get the water adjusted, then she placed the resident in his wheelchair and brought him out of the shower. He continued to be agitated for the duration of 20-30 minutes following the shower attempt and he did not allow LPN #2 to attempt his accucheck until later. LPN #2 indicated, the facility did not have a tub bath to offer as an alternative approach to the shower for this resident. She indicated as far as she knew the staff had not tried any other alternative means to offer to routinely bathe this resident. She indicated if the resident was offered an alternative means of bathing there should have been documentation in the nurses notes and the alternative bathing method would have been documented on the "CNA Assignment Sheet." 3.1-3(u)(3)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a comprehensive Care plan for resisting care, refusing showers and services for 1 out of 16 residents reviewed for Care	F000279	The facility acknowledges that F242 and F279 are in regards to the same resident and same issue. 1.Changes were made to Resident #15 plan of care on	06/13/2014

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	Plans. (Resident #15) Findings include: Resident #15's record was reviewed on 5/15/14 at 7:12 A.M. Diagnoses included, but were not limited to, vascular dementia, diabetes mellitus, and depression. A document titled "Daily skilled Nursing Assessment" dated 4/28/14, indicated in the "Comment" section at 4:30 P.M., the resident had received a shower in the A.M., and the CNA indicated the resident was yelling out and combative during the shower. The CNA indicated there was nothing wrong with him, he just yelled out and he continued to yell out until the shower was completed. A document titled "Daily Skilled Nursing Assessment" dated 5/9/14 at 7:55 A.M., indicated in the "Comment" section that the resident had refused his shower on this A.M. after "multiple attempts". The staff indicated when the resident was queried why he did not want to take a shower, he had indicated, "Because I want to stink." After the staff explained to the resident that he could go one time a week without taking a shower and inquired why he wanted to "stink" the resident indicated, "To keep everyone		5/16/14 to reflect resisting care, and refusing showers during the survey process, therefore have already been addressed. 2.There were no other residents affected. 3.In an effort to ensure ongoing compliance, any resident with evidence of resistance to care will have it addressed in that individuals care plan. CNA's are responsible for filling out a bathing/shower sheet each time they assist a resident with a shower or bath. The bathing/shower sheets have been updated to include alternatives offered as well as any behaviors exhibited during bathing. The MDS/Care Plan RN will audit nurses' notes of residents in the Medicare unit weekly to ensure that their plan of care is reflective of any resistance of care and that interventions are put in place. 4. As a means of quality assurance, results of the weekly audits of nurses notes will be reviewed with the Quality Assurance Committee, quarterly.	

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	away." He refused to allow the staff to shave his mustache. A document titled "Daily Skilled Nursing Assessment" dated 5/13/14, indicated in the "Comment" section at 12:10 P.M., the resident became combative, attempted to hit staff and attempted to stand up off the shower chair and "almost fell to the floor." The resident yelled at the staff to keep the water off him because it was "hot." The note indicated a "Behavior Referral Form" was completed for Social Services. A document titled "Nursing Assistant Skin Observation Report With Shower/Bath" dated 5/13/14, indicated the resident was combative and calling out during the shower and he refused the shower. A document titled "Behavior Health Referral" dated 5/13/14 indicated "Describe the behavior or action: attempting to hit staff, hitting staff. yelling, cussing at staff. Location, Date and Time: 5/13/14. Duration (5 min, 30 min, 3 hours): 20-30 minutes, Intentional and Defensive What occurred prior: attempting to do care, shower, and accucheck. Environmental triggers: shower [water was to hot], CNA made sure water was cool to touch, still c/o			

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	[complains of] being to hot. Temperature of room: warm...Was resident trying to communicate something: that he didn't want a shower Told staff on 5/9/14 when he refused shower he wanted to stink...." During the clinical record review there were no Care Plans for resisting care, refusing showers or accucheks found documented. During an interview on 5/16/14 at 10:10 A.M., LPN #2 indicated on 5/13/14, when the CNA attempted to give the resident his shower, he refused due to the water was "hot" and she attempted to adjust the water. When the CNA could not get the water adjusted, then she placed the resident in his wheelchair and brought him out of the shower. He continued to be agitated for the duration of 20-30 minutes following the shower attempt and he did not allow LPN #2 to attempt his accucheck until later. During an interview on 5/16/14 at 3:13 P.M., the Nurse Manager indicated the resisting care, refusing showers and accucheck Care Plans were not initiated by the MDS (Minimum Data Set) Coordinator until 5/16/14, after the issue regarding not having Care Plans for these concerns were brought to the Administrator and DoN's attention on			

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	5/15/14 at 4:40 P.M. 3.1-35(a) 3.1-35(b)(2)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure Plan of Care interventions were implemented, related to repositioning as a treatment to heal a pressure ulcer; for 1 of 11 residents reviewed for Care Plans. (Resident #9) Findings follow: On 5/12/14 at 2:14 P.M., Resident #9 was observed laying in bed, on her back,	F000282	1.All CNAs go through skills training upon hire and an annually in a CNA workshop where skills including repositioning and following assignment sheets/care plans are addressed. The CNA caring for Resident #9 on 5/15/14 was immediately re-in-serviced on following residents' plan of care and repositioning. 2.There were no other residents affected. 3.In an effort to ensure ongoing compliance, a mandatory all	06/13/2014

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	with her eyes closed. In an interview on 5/13/14 at 10:00 A.M., LPN #5 indicated the resident had a Stage 2 pressure ulcer on her left buttock, which was acquired in the facility. On 5/13/14 at 9:00 A.M., the resident was observed up in her wheelchair in the Activity/Lounge room. The resident remained up in her wheelchair until after the lunch meal. At 1:40 P.M., the resident was transferred into bed from the wheelchair with a Hoyer (mechanical) lift. During an interview at 1:40 P.M., a family member indicated the resident becomes very tired when up all morning. She indicated the resident seemed very tired at lunch, and figured the resident had been up a long time. On 5/13/14 at 3:15 P.M., the resident was observed to be in bed, laying on her back. There was a specialty foam pressure-relief mattress overlay on the bed. On 5/14/14 at 10:20 A.M., the resident was out of her room. A 3 to 4-inch foam "waffle" type mattress overlay, for pressure relief, was observed on top of the mattress. The resident was located in the therapy department, and was observed to be transferred by one		health center nursing staff in-service with signature required will be conducted 6/3/14 and 6/10/14 to review following residents plan of care, including repositioning of dependent residents. 4.As a means of quality assurance, nurses will perform weekly audits to ensure residents plan of care for offloading and repositioning is being followed. Results of the audits will be shared with the Quality Assurance Committee quarterly.	

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	Physical Therapy staff member, using gait belt, from wheelchair to regular chair. The resident was able to bear some weight, and was able to perform a pivot with maximum assistance from the therapist. There was a leather/vinyl covered gel pressure-relief cushion in wheelchair. On 5/14/14 at 11:10 A.M., the resident was observed sitting in her wheelchair in the lounge area across from the Nurse's Station. She was awake and looking around. On 5/14/14 at 1:10 P.M., a family member was in the room with the resident. The resident was in her wheelchair. The family member indicated she had been with the resident since before lunch, about 11:30 A.M., and the resident had been up in her wheelchair since then. On 5/15/14, a continuous observation was made from 10:30 A.M. to 12:30 P.M. At 10:30 A.M. the resident was observed sitting in her recliner in her room, with the back of the chair at 90 degree angle. Her legs were elevated on the foot rest. The gel cushion was in the wheelchair. At 11:30 A.M., a Certified Occupational Therapy Assistant (COTA) entered the room, and remained until			

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	155472	A. BUILDING 00 B. WING	05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

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	11:45 A.M. The COTA was observed kneeling by the recliner, and talking with the resident. At 12:30 P.M., the resident's lunch tray was delivered. The resident remained in the recliner chair. The gel seat pad was observed to be in the wheelchair. CNA #3 indicated she would lay the resident down after lunch, probably in about an hour. No nursing staff were observed to go into the resident's room between 10:30 A.M. and 12:30 P.M. On 5/15/14 at 1:30 P.M., the resident was observed to be in her bed. CNA #5 and CNA #4 indicated they had just transferred the resident into bed using the mechanical lift. After rolling the resident to her left side, CNA #5 used a disposable wipe to clean the resident's rectal and buttock area. The adult brief that had been on was wet with urine, and both buttock areas were reddened with white "wrinkle" marks. There was a small (pencil point) round open area on the lower right buttock. There was a white colored, irregular-edged area at the coccyx that appeared to be scar tissue. No open area was observed on the left buttock. After cleaning the resident's bottom and applying a clean brief, the CNAs positioned the resident on her back.			

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	The clinical record was reviewed on 5/15/14 at 10:40 A.M. Diagnoses included, but were not limited to, recent history of a left hip fracture with open reduction/internal fixation, chronic pain, history of weight loss, vascular dementia, seizures, congestive heart failure, chronic urinary tract infection, constipation, hypoxia, and history of a cerebral vascular accident (CVA/stroke) with expressive aphasia. The May, 2014 Physician Order recap (recapitulation) form included current orders, with date ordered, as: 4/9/14--Anti-pressure wheelchair cushion as pressure relief. 4/9/14--Foam overlay as pressure relief. 4/19/14--Keep off of back when in bed until open area heals. One Care Plan entry addressed a problem of "(2/5/13) Potential for skin breakdown related to incontinence and decreased mobility;" and "(Not dated) Open areas to buttocks." Interventions included, but were not limited to, the following: "Barrier creams after each incontinent episode; foam overlay to be placed on mattress for pressure relief; cushion in wheelchair for pressure relief; reposition side to side." A "Medicare CNA Assignment" sheet,			

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	updated 5/14/14, indicated "Get up between 7-8:30 A.M.; bed right after dinner; Hoyer lift; Reposition every 2 hours." During a conference on 5/15/14 at 4:30 P.M., the Administrator and Director of Nurses were given the opportunity to provide any information/documentation related to the off-loading/repositioning of the resident. On 5/16/14 at 10:10 A.M., the Administrator provided a typed note, dated 5/15/14 (no time listed). She indicated the documentation on the note was the responses from interviews with the Physical Therapist Assistant (PTA) and Certified Occupational Therapy Assistant (COTA) who worked with Resident #9 on 5/15/14. The noted indicated "Per therapist [PTA #7], with HTS [the contracted therapy company], he entered [the resident's name] room between 11:30 am-12 noon. She was up in her chair. He went in to assess her," and "Therapist [COTA #8), with HTS, stated she went in to [resident's name] room after [PTA #7]. Resident still in her chair. [COTA #8] repositioned resident to include her legs/footrests so as to facilitate a more comfortable position for the resident."			

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	In an interview on 5/16/14 at 2:55 P.M., COTA #8 indicated the resident's feet were elevated on the recliner foot rest when she went into the room. She lowered the foot rest to have room to place an over-bed table closer to the resident. She indicated that was all she did--she did not move any other part of the resident's body. In an interview on 5/16/14 at 3:00 P.M., PTA #7 indicated he was in the resident's room for 15 minutes. He indicated the resident was very tired and resistant to any care. He indicated he gently moved her legs on the foot rest, but did not attempt to get her up. 3.1-35(g)(2)			
F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from			

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	developing. Based on observation, interview and record review, the facility failed to ensure 1 resident, who had pressure ulcers, was repositioned/off-loaded from her bottom in order to assist in the healing of Stage 2 pressure ulcers, for 1 of 2 residents reviewed for pressure ulcers. (Resident #9) Findings include: On 5/12/14 at 2:14 P.M., Resident #9 was observed laying in bed, on her back, with her eyes closed. In an interview on 5/13/14 at 10:00 A.M., LPN #5 indicated the resident had a Stage 2 pressure ulcer on her left buttock, which was acquired in the facility. On 5/13/14 at 9:00 A.M., the resident was observed up in her wheelchair in the Activity/Lounge on NCC (Non-Certified Comprehensive) wing. The resident remained up in her wheelchair until after the lunch meal. At 1:40 P.M., the resident was transferred into bed from the wheelchair with a Hoyer (mechanical) lift. During an interview at 1:40 P.M., a family member indicated the resident becomes very tired when up all morning. She indicated the resident seemed very tired at lunch, and figured the resident	F000314	The facility acknowledges F282 and F314 are in regards to the same resident and same issue. 1.All CNA's go through a skills training initially upon hire and an annual CNA workshop where skills including repositioning and following residents plan of care are addressed. The CNA caring for resident #9 on 5/15/14 was immediately re-in-serviced on following residents' plan of care and repositioning. 2.There were no other residents affected 3.In an effort to ensure ongoing compliance, A mandatory nursing in-service with signature required will be conducted on 6/3/14 and 6/10/14 to review following a residents plan of care. 4.As a means of quality assurance, spot check audits to ensure residents plan of care for offloading and repositioning will be performed by nurses. Results of the audits will be shared with the Quality Assurance committee quarterly.	06/13/2014

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	had been up a long time. On 5/13/14 at 3:15 P.M., the resident was observed to be in bed, laying on her back. There was a specialty foam pressure-relief mattress overlay on the bed. On 5/14/14 at 10:20 A.M., the resident was out of her room. A 3 to 4-inch foam "waffle" type mattress overlay, for pressure relief, was observed on top of the mattress. The resident was located in the therapy department, and was observed to be transferred by one Physical Therapy staff member, using gait belt, from wheelchair to regular chair. The resident was able to bear some weight, and was able to perform a pivot with maximum assistance from the therapist. There was a leather/vinyl covered gel pressure-relief cushion in the wheelchair. On 5/14/14 at 11:10 A.M., the resident was observed sitting in her wheelchair in the lounge area across from the Nurse's Station. She was awake and looking around. On 5/14/14 at 1:10 P.M., a family member was in the room with the resident. The resident was in her wheelchair. The family member			

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	indicated she had been with the resident since before lunch, about 11:30 A.M., and the resident had been up in her wheelchair since then. On 5/15/14, a continuous observation was made from 10:30 A.M. to 12:30 P.M. At 10:30 A.M. the resident was observed sitting in her recliner in her room, with back of chair at 90 degree angle. Her legs were elevated on the foot rest. The gel cushion was in the wheelchair. At 11:30 A.M., a Certified Occupational Therapy Assistant (COTA) entered the room, and remained until 11:45 A.M. The COTA was observed kneeling by the recliner, and talking with the resident. At 12:30 P.M., the resident's lunch tray was delivered. The resident remained in the recliner chair. The gel seat pad was observed to be in the wheelchair. CNA #3 indicated she would lay the resident down after lunch, probably in about an hour. No nursing staff were observed to go into the resident's room between 10:30 A.M. and 12:30 P.M. On 5/15/14 at 1:30 P.M., the resident was observed to be in her bed. CNA #5 and CNA #4 indicated they had just transferred the resident into bed using the mechanical lift. They were observed to have pulled resident's pants down to her			

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	knees and had undone the adult brief. After rolling the resident to her left side, CNA #5 used disposable wipes to clean the resident's rectal and buttock area. The adult brief that had been on was wet with urine, and both buttock areas were reddened with white "wrinkle" marks. There was a small (pencil point) round open area on the lower right buttock. There was a white colored, irregular-edged area at the coccyx that appeared to be scar tissue. No open area was observed on the left buttock. After cleaning the resident's bottom and applying a clean brief, the CNAs positioned the resident on her back. The clinical record was reviewed on 5/15/14 at 10:40 A.M. Diagnoses included, but were not limited to, recent history of a left hip fracture with open reduction/internal fixation, chronic pain, history of weight loss, vascular dementia, seizures, congestive heart failure, chronic urinary tract infection, constipation, hypoxia, and history of a cerebral vascular accident (CVA/stroke) with expressive aphasia. An acute care hospital "Admission History and Physical" report, dated 4/3/14, indicated the resident was "awake, alert, does not follow commands, not oriented to person, place			

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	or time. Significant dementia as well as previous stroke with expressive aphasia. She is essentially confided to a wheelchair and does not ambulate." A facility "Admission Nursing Assessment," dated 4/9/14, indicated "Skin: surgical incision left hip, bruise back of left and right hands." Two "Braden" pressure ulcer risk assessments, dated 4/9/14 and 5/6/14, indicated the resident had scores of "14" and "13" ("Total score of 12 or less represents HIGH RISK"). The May, 2014 Physician Order recap (recapitulation) form included current orders, with date ordered, as: 4/9/14--WBAT (weight bear as tolerated) LLE (left lower extremity) 4/9/14--Anti-pressure wheelchair cushion as pressure relief. 4/9/14--Foam overlay as pressure relief. 4/9/14--Moisture barrier cream to peri-anal area every shift and PRN (as needed). 4/19/14--Calmoseptine apply topically to open area right upper buttock every shift and PRN until healed. 4/19/14--Keep off of back when in bed until open area heals. Other MD orders included, but were not			

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	limited to, the following: 5/9/14--Discontinue order for Calmoseptine to right buttock--open area healed. A Physician progress note, dated 5/5/14, indicated: "Pt. (patient) has a Stage lll pressure ulcer on her left buttock per nurse. She is at risk for skin breakdown due to immobility, incontinence, and decreased sensory abilities. She is currently on a pressure relief pad in her bed and wheelchair and is put in bed after meals. Staff has been applying Calmoseptine to the area. Skin--left buttock, small stage ll pressure ulcer approx. 0.25 by 0.25 by 0.25 cm. Nurse reports it looks much better than it did last week, not as deep...." The "Daily Skilled Nursing Assessment" notes indicated the following: 4/19/14, at 2:35 P.M.--"CNA reported to this nurse earlier resident has open area to right buttock. Noted Stage 2 crescent-shaped open area to right upper buttock...." 4/20/14--Left hip (surgical incision) and right upper buttock. 5/7/14--right and left buttocks. 5/8/14--left buttock and right buttock. Treatment to open area on left buttock done as ordered. 5/9/14--left buttock. Treatment to open			

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	left buttock done as ordered. 5/11/14--left buttock. Open area to left buttock slowly healing. 5/13/14--left buttock. Treatment of open area left buttock done as ordered. Wound bed with healthy pink granular tissue present. In an interview on 5/16/14 at 3:30 P.M., LPN #5 indicated the resident has had open areas on both her right and left buttock areas. The "Wound Assessment Form" reports indicated the following: 4/19/14--Right upper buttock, Stage 2, shearing, 1.7 by 0.7 by 0.1 cm (centimeter) 4/25/14--Right upper buttock, Stage 2, 1.5 by 1.0 by 0.1 cm. 5/3/14--Right buttock, pressure. Right buttock wound healed fragile. 5/3/14--Left buttock, Stage 2, pressure; 0.3 by 0.2 by 0.2 cm. 5/9/14--Left buttock, Stage 2, pressure; 0.3 by 0.3 by 0.2 cm. No change in wound this week. One Care Plan entry addressed a problem of "(2/5/13) Potential for skin breakdown related to incontinence and decreased mobility;" and "(Not dated) Open areas to buttocks." Interventions were listed as: "Encourage to drink fluids daily; barrier			

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	creams after each incontinent episode; treatment as ordered; encourage out of bed activities; labs as ordered; foam overlay to be placed on mattress for pressure relief; provide diet as ordered; cushion in wheelchair for pressure relief; continue on supplements for wound healing; reposition side to side." A "Medicare CNA Assignment" sheet, updated 5/14/14, indicated "Get up between 7-8:30 A.M.; bed right after dinner; Hoyer lift; Reposition every 2 hours." During a conference on 5/15/14 at 4:30 P.M., the Administrator and Director of Nurses were given the opportunity to provide any information/documentation related to the off-loading/repositioning of the resident. On 5/16/14 at 10:10 A.M., the Administrator provided a typed note, dated 5/15/14 (no time listed). She indicated the note was the responses from interviews with the Physical Therapist Assistant (PTA) and Certified Occupational Therapy Assistant (COTA) who worked with Resident #9 on 5/15/14. The noted indicated "Per therapist [PTA #7], with HTS [the contracted therapy company], he entered [the resident's name] room between 11:30			

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	am-12 noon. She was up in her chair. He went in to assess her. Therapist [COTA #8), with HTS, stated she went in to [resident's name] room after [PTA #7]. Resident still in her chair. [COTA #8] repositioned resident to include her legs/footrests so as to facilitate a more comfortable position for the resident." In an interview on 5/16/14 at 2:55 P.M., COTA #8 indicated the resident's feet were elevated on the recliner foot rest when she went into the room. She lowered the foot rest to have room to place an over-bed table closer to the resident. She indicated that was all she did--she did not move any other part of the resident's body. In an interview on 5/16/14 at 3:00 P.M., PTA #7 indicated he was in the resident's room for 15 minutes. He indicated the resident was very tired and resistant to any care. He indicated he gently moved her legs on the foot rest, but did not attempt to get her up. 3.1-40(a)(1)			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -			

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	(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure 1 of 1 facility kitchen food storage areas, food prep areas, and food equipment were maintained in a safe and sanitary manner, and followed sanitation and food safety policies and procedures. This deficiency impacted 11 of 11 residents who received food from the kitchen. Findings include: On 5/12/14 at 10:30 A.M., the kitchen tour was completed, with the Registered Dietician (RD) and the Dining Supervisor in attendance. The following was observed: One "well" pan had dried debris inside on the bottom of the pan. Another "well" pan had moisture on the inside walls, which dripped down the inside walls when picked up. In an interview at that time, the RD indicated the pans should have no debris or moisture in them. The oven had a baked, black residue inside on the bottom of the oven floor. In an interview at that time, Dietary Cook #13 indicated the oven was cleaned	F000371	1.On 5/12/14, the "well" pans with debris & wet were removed from use and taken to the dish room for cleaning and sanitizing. 2.The well pan was removed from service, therefore no residents were affected. 3.In an effort to ensure ongoing compliance, all Health Center Dining Services Employees will be re-trained per policy on proper cleaning, air-drying, and inverted storage of pans per policy. Staff in-service to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff will ensure this practice is followed on a consistent basis by the daily Utility Staff Checklist. Weekly random visual checks will be conducted by a dietary manager. 4.As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. 1. On 5/12/14 the black spill in the oven was cleaned. 2. The spill in the oven was immediately cleaned, therefore there were no residents affected. 3. In an effort to ensure ongoing compliance, all Dietary Health Center Production Employees will be re-trained per policy, on proper oven & equipment cleaning. Staff	06/13/2014

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	weekly. He believed the weekend staff were to clean it. A sanitation bucket containing a sanitizing solution was observed sitting on the food prep table. In an interview at that time, Dietary Cook #15 indicated he had changed the solution in the bucket at around 9:30 A.M. Dietary Aide #14 checked the concentration of the sanitation solution in the bucket, and indicated it was reading at 100 parts per million (ppm) She indicated the sanitation solution should be at 200 ppm. Eleven uncovered bowls of ice cream were observed on the middle shelf in one of three freezers. The RD indicated the ice cream should have been covered. An ice scoop was observed to be in the ice in the ice machine. The Dining Supervisor indicated the scoop should not be left in the ice inside of the ice machine. The floor underneath a food rack in the dry storage room was observed to have a large dark spot of debris. The Dining Supervisor indicated staff were supposed to sweep and mop daily in dry storage area, but the staff must have missed that area.		in-service to be conducted on 6/4/14, 6/11/14, and 6/12/14. Random weekly visual checks will be conducted by a dietary manager to ensure proper oven and equipment cleaning is being done4. As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. 1.The sanitation bucket was immediately removed and replaced with sanitizing solution at 200 ppm. 2.The sanitation solution was replaced with solution that was 200ppm, therefore no residents were affected. 3.In an effort to ensure ongoing compliance, all Health Center Dining Services Employees will be re-trained per policy on proper use of sanitizing solution and frequency of changing sanitation solution per policy. Staff in-service to be conducted on 6/4/14, 6/11/14, and 6/12/14. Health Center Dining Services Employees and management will ensure the sanitation solution is being changed per policy as evidenced on the daily Utility Staff Checklist. Random weekly visual checks will be conducted by a dietary manager to ensure the sanitizing solution has been changed out and at the appropriate concentration. 4.As a means of quality	

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	The policies for the ice machine, covering of food in freezer, schedule for cleaning of ovens and the dry storage rack areas were requested at that time. On 5/12/14 at 3:30 P.M., the Registered Dietician provided the following documentation, which she indicated was all she could find: An undated document, titled "The Cooks Cleaning Schedule," was typed out indicating which days of the week which tasks were to be completed. There was no indication on the list regarding the cleaning of ovens. An undated document, titled "The Servers Extra Cleaning," indicated the dry storage area was to be organized, swept and mopped on Thursdays. An undated document, titled "Food Handling Guidelines (HACCP)," indicated "...page 5 of 6...COOLING...When the food is placed in the cooling equipment (walk-in, blast chiller, etc.) : ...Loosely covered or uncovered if protected from overhead contamination..." An undated document, titled " EcoLab Sanitizer Technical Data Sheet," indicated, "...the concentration of the quat		assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. D. 1.The eleven ice creams were immediately discarded. 2.The eleven ice creams were immediately discarded therefore there were no residents affected. 3.All Health Center Dining Services Employees will be re-trained on proper covering, labeling, and dating of products per policy. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Dining Services staff and management will ensure this practice is followed on a consistent basis by the daily Dining Staff Checklist. Random weekly visual checks will be conducted by a dietary manager to ensure staff are coving, labeling and dating products appropriately. 4.As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. E. 1.The Manitowac ice machines are designed with a ledge inside the bin that holds the scoop, while not allowing it to touch the ice. This is consistent with the department policy. 2.There were no residents	

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	sanitizing solution must be between 200-400 ppm...." A Policy, titled "Sanitation and Infection Control Ice Handling" and dated 5/95 with a revision date of 1/14, indicated "...All food and Nutrition Services Department associates...Store the scoop in a self-draining container in an area protected from contamination. The scoop cannot be stored in the ice bin...." 3.1-21(i)(3)		affected. 3.In an effort to ensure ongoing compliance, all Health Center Dining Services Employees will be re-trained on proper storage of the ice scoop. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Dining Services staff and management will ensure this practice is followed on a consistent basis by the daily Dining Staff Checklist. Random weekly visual checks will be conducted by a dietary manager staff are following ice scoop storage policy. 4.As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. F. 1.The spot of debris observed on the floor underneath the food rack in the dry storage area was estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2.There were no residents affected. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14,	

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			6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily Utility Staff Checklist. Random weekly visual checks will be conducted by a dietary manager to ensure routine cleaning is being completed. 4.As a means of quality assurance, the weekly random visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly.	
F000411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to ensure dental status was assessed, and assistance in obtaining dental services was provided, for 1 resident who had experienced tooth loss; for 1 of 1 resident reviewed for dental issues. (Resident #9)	F000411	The facility is requesting a face to face IDR for F411. Hoosier Village consistently complies with the regulation to assist residents in obtaining routine and 24-hour emergency dental care. As indicated by the surveyors, resident #9 was sent out for	06/06/2014

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	Findings include: In an interview on 5/13/2014 at 1:09 P.M., a family member indicated Resident #9 had lost 2 teeth following her recent hip surgery. The family member indicated she had not yet made an appointment with dentist. The family member indicated nursing staff were aware the resident had lost teeth, and were checking on her ability to chew. She indicated the resident was recently placed on a on a mechanical soft diet. The clinical record was reviewed on 5/15/14 at 10:40 A.M. Diagnoses included, but were not limited to, recent left hip fracture with open reduction/internal fixation, chronic pain, history of weight loss, vascular dementia, seizures, gastroesophageal reflux disease, congestive heart failure, chronic urinary tract infection, B-12 vitamin deficiency, constipation, and history of CVA (cerebral vascular accident/stroke) with expressive aphasia. A Physician's progress note, dated 2/28/14, indicated "Had a tooth filled and had general anesthesia--she did well; no recent falls; weight loss--gets supplements."		dental work approximately 3 months earlier for a similar dental issue. At the daughter's request, she made that appointment at her convenience and notified nursing staff who then arranged transportation for the resident, which is in accordance with the regulation F 411. Resident # 9's daughter visits her mother on a daily basis and has requested to be responsible for making any appointments for her mother. As noted by the surveyor, this was documented in the Care Plan dated 2/5/13 for a problem addressed as "Dental Care" and an intervention which stated "family will decide on follow-up care." On 5/10/2014, Resident #9's daughter notified nursing staff that her mother's tooth was missing but that she wanted to wait until later to make a dental appointment. There were no indications – bleeding, grimaces, change in appetite, etc. - that emergency care was needed. In fact, as stated by the surveyors, nurses documentation indicate that the resident had a good day, ate 100% of her breakfast, and took all of her medications without difficulty. As a precaution to prevent chewing issues, the resident was placed on a mechanical soft diet. The nurse did assess the resident's mouth as stated in the nurses notes and in verbal conversation with the surveyor on 5/15/2014. In follow up conversation with Resident	

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	A "Care Plan Review" form, dated 3/4/14, indicated "Resident missing 1/2 front tooth." A Nurse's Notes entry, dated 5/10/14 at 2:45 P.M., indicated "[Family member] at Nurses Station. States resident has a tooth missing. Resident has had a good day today. Ate 100% breakfast this morning. Took all meds [medications] with no difficulty... Tooth with brown color to top of tooth where broken off...." There were no subsequent Nurses progress notes related to the broken tooth. There were no Social Service notes related to the resident's dental status. The May, 2014 Physician Order recap (recapitulation) sheet, included current orders, with the date ordered, as follows: 4/9/14--Regular diet 4/9/14--Tylenol 325 mg. (milligrams)--take 2 tablets QID (four times a day) 4/10/14--Ensure 1 bottle in between meals--Dx. supplement 4/24/14--Carnation Instant Breakfast--mix 1 packet in carton of milk at lunch and dinner. 4/9/14--Weekly weight on Sunday. The resident was also receiving a		#9's daughter on 5/19/2014, the daughter again stated, this time to the Director of Nursing, that she did not want her mother sent to the dentist at this time and that she would make the appointment at a later time. Due to the resident's debility, she requires general anesthesia for any dental work, including that which is routine. Since the resident has recently fractured her hip requiring surgery under general anesthesia, the daughter does not want her undergoing anything else at this time. Since the discovery of the missing tooth, the resident has not displayed any adverse symptoms, i.e., facial grimaces, crying out, a change in eating patterns, fever, that indicate a need for emergent care. To comply with regulation 411, nursing staff are not required to make a referral to the social services designee for emergent or routine dental needs. Nursing staff can, and do, initiate conversations with families and assist with making dental appointments if the resident or their representative agrees. In this case, the daughter noticed the tooth missing, notified the nursing staff, and told them she did not want an appointment made or her mother sent out. She verified this same decision again on 5/19/2014 with the DON. In further compliance with regulation F 411, it is not necessary for Hoosier Village staff to assist	

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	Fentanyl (an opioid pain medication) patch. Other Physician orders included: 5/1/14--"Mechanical soft/ground meat; thin liquids. Recommend 1 box Resource Breeze daily--chart amount consumed per MAR (Medication Administration Record)--poor P.O. (by mouth, oral), wound, weight down." In an interview on 5/15/14 at 4:00 P.M., LPN #5 indicated she knew about the missing tooth. She indicated that LPN #12 was here at that time, and had written the Nurses progress note. In an interview at that time, LPN #12 indicated the family member came to her, and told her the resident was a missing tooth. She and CNA #3 checked the resident's room, but could not find a tooth, which she thought was a little strange. The nurse indicated she did see part of the tooth in the resident's mouth--it looked liked the tooth had broken off. She indicated the resident did not seem to be having any pain at that time. The family member vaguely mentioned making appointment with a dentist, but the nurse did not question her any further. The nurse did not do anything else. Because the resident was frequently resistive to care, she did not try to		Resident #9's daughter in making appointments. As in the past, however, Hoosier Village will make transportation arrangements to and from the dentist's office when the appointment has been sent by the daughter. 1.Resident #9 was assessed for pain/discomfort or swallowing issues when it was noticed that she had lost a tooth. Resident did not display any pain, or discomfort and was changed to a mechanical soft diet to assist with chewing foods. Staff has discussed with daughter, who makes all decisions in regards to doctor visits, etc. and the daughter continues to want to wait to have her mom sent to the dentist. 2.There were no other residents affected. 3.In an effort to ensure ongoing compliance, the social services designee will address with residents and families during each care plan meeting dental services both routine and emergent. The facility will ensure that necessary dental work is completed by maintaining an appointment tracking log in each residents chart in the care plan section. The appointment tracking log will include Dental, Vision, Audiology and Podiatry appointments. (attachment #2). 4.As a means of quality assurance, the care plan coordinator will audit care plan	

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	examine the resident's mouth extensively. The nurse indicated she did not report the dental issue to Social Service, and did not do any other follow up. One Care Plan, dated 2/5/13, addressed a problem of "Dental Care," and indicated "No problems at this time. Resident has some of her own teeth as well as a partial bridge." The interventions, dated 2/5/13, were listed as: "Monitor oral hygiene; lay out supplies for tooth brushing; family will decide on follow-up care; gentle oral care; maintain contact isolation." 3.1-24(a)		meeting notes and the appointment tracking log monthly to ensure that dental services has been offered and addressed with families. Results of audits will be reviewed with the Quality Assurance committee quarterly.	
F000505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on interview and record review, the facility failed to report accucheck results to the Physician in a timely manner for 2 of 2 residents reviewed for reporting accucheck results to the Physician. (Resident #10 and #15) Findings include: 1. Resident #10's record was reviewed	F000505	The facility is requesting a face to face IDR for F505. The facility believes we have met the requirement of notifying the physician promptly for lab results, in this case finger stick blood sugars. Documentation shows that the physician was promptly notified and new orders were received for both resident #10 and resident #15. In all instances blood sugars were called to the physician, the nurse received a	06/11/2014

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	on 5/15/14 at 1:43 P.M. Diagnoses included, but were not limited to, hyperglycemia, and diabetes mellitus. A "Blood Sugar Monitoring Sheet" with a date 4/26/14, indicated a blood sugar at 6:00 A.M., of 311 for the resident. A Nurse's Note dated 4/26/14 at 12:30 P.M., indicated "...Also, BS [blood sugar] this AM 311. Order given to give 6 units Novolog SQ [subcutaneous] as was scheduled for accucheck of 300...." A Physician's Order dated 4/26/14 at 5:30 P.M., indicated "Give 6 units Novolog insulin for BS of 311...." During an interview on 5/16/14 at 10:00 A.M., the Administrator indicated, LPN #12 had contacted the doctor, gotten orders and had given the insulin for a 6:00 A.M., blood sugar of 311 on 4/26/14 at 9:00 A.M. The Administrator had provided a copy of a screenshot picture of the MAR (Medication Administration Record) order with the time LPN #12 had signed the insulin off as being administered. The April 2014 Physician order recap (recapitulation) sheet included, but were not limited to the following orders: 4/26/14--Aspart Insulin 100 units/ml		return call, new orders were received and administered within 2-3 hours. The facility Medical Director, Dr. Diane Healey confirms that nursing staff notified the physician or on call physician with the documented blood sugars in an appropriate time frame. 1.Resident #10 had a blood sugar of 311, results were called to the on call physician and new orders were received and insulin given. Resident #15 had a blood sugar of 374 and the on call doctor was notified, orders were received and insulin given. 2.There were no other residents affected 3.In an effort to ensure ongoing compliance, a health center nurses mandatory in-service on 6/3/14 and 6/10/14 included the review of the physician call orders for blood sugars, and to document in nurses notes when the physician was called, when received return call and when orders were received and administered for finger stick blood sugars. Nurses will document those residents that have routine blood sugars and insulin on the nurses 24 hour report sheet. The report sheet will be audited weekly to ensure that nursing staff is notifying the physician of out of range blood sugars promptly and that nurses notes reflect when calls to the physician are made and when orders are received.	

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	(milliliters) Give per sliding scale Subcutaneous twice daily. Give nothing for accucheck below 200. 201-250=Give 4 units. 251-300=Give 6 units 301-350=Give 8 units 4/25/14--Accuchecks twice daily 0600 (6:00 A.M.) and 1600 (4:00 P.M.) . Call results < (below) 70 or > (above) 300. 2. Resident #15's record was reviewed on 5/15/14 at 7:12 A.M. Diagnoses included, but were not limited to, acute renal failure, chronic kidney disease Stage 3, and diabetes mellitus. A "Blood Sugar Monitoring" sheet indicated the resident had a blood sugar of 360 on 4/24/14 at 11:00 A.M. A Nurse's Note dated 4/24/14 at 12:00 P.M., indicated the resident's accucheck was 360 and the Nurse Practitioner was notified and a new order was given. A "Blood Sugar Monitoring" sheet indicated the resident had a blood sugar of 374 on 4/27/14 at 11:00 A.M. A Nurse's Note dated 4/27/14 at 1:15 P.M., indicated the doctor was notified and a new order for 8 units of Novolog of insulin now was received one time only.		4.As a means of quality assurance, the weekly audits will be reviewed with the Quality Assurance Committee quarterly.	

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	A Physician's order dated for 4/27/14 at 1:30 P.M., indicated "Give 8 units Novolog insulin @ [at] this time for accucheck of 374-1 x [time] only." A "Blood Sugar Monitoring" sheet indicated the resident had a blood sugar of 457 on 5/2/14 at 4:00 P.M. A Nurse's Note dated 5/2/14 at 5:30 P.M., indicated "Accucheck 456 reported to (name of Nurse Practitioner) N.O. [new order] received." A Physician's order dated 5/2/14 at 5:30 P.M., indicated "Increase levemir [Insulin medication] to 22 units q [every] am." The April 2014 Physician order recap sheet included, but were not limited to the following orders: 4/8/14--Accuchecks three times a day before meals. Record on BS (Blood Sugar) flowsheet. Call MD if BS <70 or >350. 4/30/14-Accuchecks three times a day before meals. Document results on the flowsheet on the MAR. Call with results below <70 or >450. During an interview on 5/15/14 at 4:40 P.M., the Director of Nursing indicated she expected the length of time a nurse was to wait to notify a Physician a blood			

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	sugar result was below or above the call parameters was not to be four hours. 3.1-49(e)(2)			
F009999	3.1-3 RESIDENT RIGHTS (v)(1) A resident has a right to the following: (1) Reside and receive services in the facility with reasonable accommodations of the individual's needs and preferences , except when the health or safety of the individual or other residents would be endangered. This rule was not met as evidenced by: Based on interview and record review, the facility failed to offer other bathing options to 1 of 5 residents reviewed for bathing choices in a sample of 6. (Resident #114) Findings include: The record review for Resident #114 was completed on 5/14/14 at 11:00 A.M. Diagnoses included, but were not limited to, dementia with behaviors, osteoarthritis, and high blood pressure.	F009999	1.Resident #114 plan of care has been modified from receiving assistance with showers to receiving assistance with bed baths. Although Resident #114 was changed from a shower to a bed bath, she continues to be agitated with any direct care provided, including but not limited to bed baths. Of note, there are several other nursing notes in the residents chart that reflect this resident becoming agitated not only with showers but with all other direct care provided due to her late stage dementia. Staff continues to use several interventions to minimize her agitation such as using a calm voice, redirection, and re-approaching at a later time. 2.There were no other residents affected. 3.In an effort to ensure ongoing compliance, a mandatory nursing in-service addressing residents rights and bathing choices will be conducted on 6/3/14 and 6/10/14. CNAS are trained to notify the nurse immediately if a resident becomes agitated. CNA's are responsible for filling out a	06/13/2014

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	The "Social Service Documentation for MDS" (Minimum Data Set) assessment, dated 6/25/13, indicated the resident was "...alert and oriented x 1. She has difficulty with her short term memory, as she is unable to recall questions writer was asking her...Resident is able to express needs at times, but due to inattention and word finding this can be difficult. She can also understand others, but due to cognitive impairment may misconstrue what is being said...." The assessment was marked as incomplete due to resident being unable to answer questions appropriately. Nurses progress notes from May 2013 through May 2014 indicated the resident displayed behaviors as follows: 7/26/13--"...Resident was given shower this shift. Resident screamed the entire shower. Resident uncooperative...." 11/20/13--"...Received shower this shift with assist of 2 aides. Very combative during shower hitting and scratching...." 11/23/13--"...Resident was combative and screaming during shower, yelling and cursing...." 12/3/13--"...Resident was very combative, hitting, cursing, and screaming during shower...." 12/6/13--"...Resident was given a shower this A.M. by this nurse and Director of		bathing/shower sheet each time they assist a resident with a shower or bath. The bathing/shower sheet has been updated to include alternatives offered as well as any behaviors exhibited during bathing. A nurse will weekly review bathing sheets to ensure that staff are following residents plan of care for bathing preferences. 4.As a means of quality assurance, audits will be reviewed with the Quality Assurance Committee quarterly. Quality of Care 1.Resident #114 was re-evaluated and by the nurse practitioner and an order was received for scheduled Tylenol. Nurses will be in-serviced to do a pain assessment on resident #114 whenever she is displaying behaviors such as agitation that could be an indication of pain. 2.There are no other residents affected. 3.To ensure ongoing compliance all nurses were in-serviced on 6/3/14 and 6/10/14 regarding monitoring for signs and symptoms of pain, using the pain assessment form, and to report and follow up with the physician. In addition, the social services designee will audit all new behavioral referral sheets weekly to ensure that the resident has been assessed for pain. 4.As a means of quality assurance, the weekly audits will be reviewed with the quality	

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	Nursing (DoN) due to concerns raised by a night shift CNA regarding combativeness of resident. The CNA had received a scratch on her arm as a result of the resident swinging at her ...Resident exhibited short bursts of yelling and cursing but was consistently consoled and assured of her safety. She swung out once or twice but did not connect with either staff nor did she cause harm to herself. CNAs will be given some examples/suggestions for showering this resident...." 12/11/13--"...Resident calm most of day but had behaviors during shower-hitting biting and screaming...." 1/22/14--"...Received shower this shift, aide instructed to slowly explain tasks before performing them, not effective cursing at staff and hitting calling the aide names...." 2/2/14--"...received shower this shift, assist of 1 and resident screaming during care...." 3/22/14--"...Resident combative during shower today. Hitting and cursing at staff...." 4/12/14--"...Resident received shower this morning and had an episode of crying...." The MDS (Minimum Data Set) assessment dated ** indicated the resident was unable to answer regarding		assurance committee quarterly. Drug Therapy The rule of each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate indications for its use. This rule was met by the facility and the facility is requesting an IDR for the following reasons.The indication for the antipsychotic medication is very clearly indicated in the residents medical chart: Dementia with behavioral disturbances. In The Nurse Practitioners and the Medical Directors notes the diagnosis for this resident is SDAT with BPSD (Senile Dementia Alzheimer's Type with Behavioral and Psychological Symptoms of Dementia). Resident #114 was started on Risperdal (an antipsychotic) on 6/8/14 when she was transferred to the health center after her husband was no longer able to care for her in the residential building due to worsening dementia with paranoia and behavioral changes. Staff in the Residential building attempted several non-medical interventions to assist the resident's husband with her care that were unsuccessful. Interventions included bringing her to the health center for group activities, assisting her son to come in and interact with her, redirection especially when she was upset with her husband, validation of her feelings, and	

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	her preferences for bathing. During an interview on 5/15/14 at 4:40 P.M., the Administrator and DoN indicated that if a resident became combative, started to yell or refused a shower after it was started the staff, was to stop the shower and attempt an alternative way to bathe the resident. The DoN indicated the CNAs have been inserviced on bathing residents, and were shown the video "Bathing without a Battle" as an instruction tool for bathing residents without the resident being combative. The DoN indicated if the resident was unable to say what their preferences were, due to dementia, they would give the resident a shower. A request for any information regarding other methods of bathing attempted for Resident #114 was requested at that time. As of the exit conference on 5/16/14 at 4:15 P.M., no further information/documentation was provided for review.. 3.1-3(v)(1) 3.1-37 QUALITY OF CARE (a) Each resident must receive and the		ADL assistance. Both the social services designee and the pharmacy consultant monitor residents on Anti-psychotics. Every effort is made to attempt to dose reduce. Of note, the facility is well within the requirements for dose reduction for this resident. The facility is requesting a face to face IDR for 9999- Drug therapyThe rule was met for the following reasons: The indication for the antipsychotic medication is very clearly indicated in resident #114 medical chart. In The Nurse Practitioners and the Medical Directors notes the diagnosis for this resident is SDAT with BPSD (Senile Dementia Alzheimer's Type with Behavioral and Psychological Symptoms of Dementia) or Dementia with behavioral disturbances.The facility attempted several non-medical interventions prior to the start of the anti-psychotic. Of note, Resident #114 was in a Residential apartment living with her husband who was providing care for her at the time that behaviors started. Staff in the Residential building did attempt several non-medical interventions to assist Mr. Snider with her care that were unsuccessful. Interventions included bringing her to the health center for group activities, her son came in several times to sit with her , redirection especially when she was upset with her husband, validation of	

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	facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan. This rule was not met as evidenced by: Based on interview and record review, the facility failed to assess and treat the pain of a resident with dementia, for 1 of 5 residents reviewed for pain in a sample of 6. (Resident #114) Findings include: The record review for Resident #114 was completed on 5/14/14 at 11:00 A.M. Diagnoses included, but were not limited to, dementia with behaviors, osteoarthritis, and high blood pressure. The "Social Service Documentation for MDS" (Minimum Data Set) assessment, dated 6/25/13, indicated the resident was "...alert and oriented x 1. She has difficulty with her short term memory, as she is unable to recall questions writer was asking her...Resident is able to express needs at times, but due to inattention and word finding this can be difficult. She can also understand others, but due to cognitive impairment may		her feelings, and ADL assistance. Resident #114 husband continued to have difficulty caring for his wife due to worsening dementia with paranoia and behavioral changes and on 6/8/14 agreed to have her transferred to the health center for comprehensive care. The antipsychotic medication, Risperdal was started a few hours after she was admitted to the health center as behaviors continued to escalate despite staff interventions. Both the social services designee and the pharmacy consultant monitor residents on Anti-psychotics. Every effort is made to attempt to dose reduce. Of note, according to the regulations addressing antipsychotic medication and gradual dose reductions, the facility is well within the requirements for dose reduction for this resident. 1.Resident #114 was admitted to the health center on 6/6/13 with a diagnosis of SDAT with BPSD and with physician orders for Risperdal. The resident will be monitored for response and continued need of Risperdal. A physician order was received for a dose reduction of the Risperdal on 5/29/14.2. There were no other residents affected.3. Licensed nurses will be in-serviced on 6/23/14 regarding assessing residents for unnecessary medications, adverse consequences of medications, progress towards	

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	misconstrue what is being said...." The assessment was marked as incomplete due to resident being unable to answer questions appropriately. The resident was in the assisted living portion of facility until 6/8/13. She was living with her husband who was unable to care for her at that time. The information for medications provided by the resident's family physician indicated upon admission to the Health Care unit, the resident had been receiving Celebrex 200 milligrams (a medication for arthritis) twice daily as needed in June of 2012 and March of 2013. The instructions for a document titled "Pain Assessment Tool" indicated the following: "Ask the resident to rate their own pain, if the resident is able to do so, using a 0 to 10 numerical rating scale. 0 indicates the absence of pain and 10 represents the most intense pain possible. Date and time the appropriate column on the table below and record the resident response in the PAIN SCORE section on the table and sign. If the resident is unable to verbally rate their own pain, the nurse observes the resident and rates their pain based on the FLACC (Face, Legs, Activity, Cry, Consolability) scale below. Date and time a column, assess each of the 5 areas with a 0, 1, or 2 response and		therapeutic goals, gradual dose reductions, and physician notification. The social service designee will identify all residents receiving psychoactive medications on the behavior monitoring sheets to track specific targeted behaviors and will audit the nurses documentation weekly for needed changes. In addition, the consultant pharmacist will audit each resident's medication regimen monthly for recommendations. The interdisciplinary team will review each resident's medication regime during the care plan review, and the Physician or Nurse Practitioner will review each resident's medications at least quarterly.4. The pharmacy consultant and social services designee audits will be reviewed at quarterly Quality Assurance meetingsFood. The facility has one kitchen that services the entire health center. The residents that are in the skilled unit and the residents that are in the non-certified beds receive food service and meals from the same kitchen. The facility was cited twice F371 and F9999(food) for the same findings by the surveyors. The Plan of Correction is the same for both. A 1.On 5/12/14, the "well" pans with debris & wet were removed from use and taken to the dish room for cleaning and sanitizing. 2.The well pan was removed	

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	then total the FLACC score. Record the total FLACC score in the PAIN SCORE on the table and sign." The FLACC portion of the assessment had the following scores: Face- 0- No particular expression or smile. 1-Occasional grimace or frown 2- frequent to constant quivering chin, clenched jaw. Legs- 0- normal position or relaxed 1- uneasy, restless or tense 2- Kicking or legs drawn up Activity- 0-Lying quietly, normal position, moves easily 1- Squirming, shifting back and forth, tense- 2- Arched, rigid or jerking Cry- 0- No cry (awake or asleep) 1- Moans or whimpers, occasional complaint 2- Crying steadily, screams or sobs, frequent complaints Consolability 0- Constant relaxed		from service, therefore no residents were affected. 3.In an effort to ensure ongoing compliance, all Health Center Dining Services Employees will be re-trained per policy on proper cleaning, air-drying, and inverted storage of pans per policy. Staff in-service to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff will ensure this practice is followed on a consistent basis by the daily Utility Staff Checklist. Weekly random visual checks will be conducted by a dietary manager. 4.As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee on a quarterly basis. B 1.On 5/12/14 the black spill in the oven was cleaned. 2.The spill in the oven was immediately cleaned, therefore there were no residents affected. 3.In an effort to ensure ongoing compliance, all Dietary Health Center Production Employees will be re-trained per policy, on proper oven & equipment cleaning. Staff in-service to be conducted on 6/4/14, 6/11/14, and 6/12/14. Random weekly visual checks will be conducted by a dietary manager to ensure proper oven and equipment cleaning is being done. 4.As a means of quality assurance, the weekly visual	

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	1- Reassured by occasional touching, hugging, or being talked to distractible 2- Difficult to console or comfort The resident's "Pain Assessment Tool" indicated the following: 6/18/13--"...complaints bilateral knee pain, unable to rate PRN Tylenol given....." 9/28/13- under the columns for the FLACC sections all indicated "0" and the Total FLACC Score was "0" 12/23/13- under the columns for the FLACC sections all indicated "0" and the Total FLACC Score was "0. Comments indicated, "...no signs or symptoms of pain/discomfort...." The Nurses Notes, dated from June 2013 through April 2014, indicated the following: 6/8/13-- Complaints of bilateral knee pain and PRN Tylenol given and taken. 7/3/13-- "...Still screaming , yelling out when CNA (Certified Nursing Aide) assist with ADL (Activities of Daily Living) 7/6/13-- "...abrupt periods of weeping and agitation..." 7/7/13--"...11:30 P.M. resident complaining of pain to knees..." 7/23/13--"...resident kicked and yelled		audits done by dietary management will be reviewed with the Quality assurance committee quarterly. C. 1.The sanitation bucket was immediately removed and replaced with sanitizing solution at 200 ppm. 2.The sanitation solution was replaced with solution that was 200ppm, therefore no residents were affected. 3.In an effort to ensure ongoing compliance, all Health Center Dining Services Employees will be re-trained per policy on proper use of sanitizing solution and frequency of changing sanitation solution per policy. Staff in-service to be conducted on 6/4/14, 6/11/14, and 6/12/14. Health Center Dining Services Employees and management will ensure the sanitation solution is being changed per policy as evidenced on the daily Utility Staff Checklist. Random weekly visual checks will be conducted by a dietary manager to ensure the sanitizing solution has been changed out and at the appropriate concentration. 4.As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee on an ongoing basis quarterly. D. 1.The eleven ice creams were	

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	during morning care..." 8/9/13--"...nurse notified by aide that resident had redness on her lower buttocks and nurse observed red, inflamed skin...resident combative with care..." 11/7/13-- Resident crying on and off all day today, Staff attempt to administer tender loving care, occasionally effective, This afternoon during care the resident was screaming ' oh my god, stop it' staff explained to resident what they were going to do and resident began to name call and cuss and scream..." 11/19/13-- "...Resident had episodes of yelling 'don't let anyone hurt my family' at CNA ..." 12/23/13--"...Resident resisting care yelling screaming do not want to lay down. it took 2 staff to put her back in bed..." 1/13/14-- "...Aides instructed to explain procedures prior to completion, this was not effective while giving hygiene care., Resident was cursing and became tearful..." 1/18/14-- "...Resident cursing and hitting and yelling at staff. Aides instructed to approach resident in calm manner when performing ADL and to explain process, this was not effective..." 2/25/14-- " ...Resident yelling and screaming during care, occasional crying episode noted..."		immediately discarded. 2.The eleven ice creams were immediately discarded therefore there were no residents affected. 3.All Health Center Dining Services Employees will be re-trained on proper covering, labeling, and dating of products per policy. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Dining Services staff and management will ensure this practice is followed on a consistent basis by the daily Dining Staff Checklist. Random weekly visual checks will be conducted by a dietary manager to ensure staff are coving, labeling and dating products appropriately. 4.As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee ongoing quarterly. E. 1.The Manitowac ice machines are designed with a ledge inside the bin that holds the scoop, while not allowing it to touch the ice. This is consistent with the department policy. 2.There were no residents affected. 3.In an effort to ensure ongoing compliance, all Health Center Dining Services Employees will be re-trained on proper storage of the ice scoop. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Dining Services staff	

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	2/28/14--"...resident had a crying spell earlier this evening..." 4/5/14--"...resident uncooperative and crying during care. no signs and symptoms of pain resident does not verbalize pain at this time..." 5/8/14-- "...Resident combative during care. scratching at CNA...distraction and re-direction unsuccessful...." The MAR (Medication Administration Record) listed the following physician orders for medications for arthritis and pain medications: 6/4/13--Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13--"Freeze It" gel to both knees three times daily. 7/11/13-- Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14--"Freeze It" gel to both knees each shift. The Tylenol 325 milligrams 2 tablets every 4 hours as needed for pain was not documented as being given from July 2013 through May 2014.		and management will ensure this practice is followed on a consistent basis by the daily Dining Staff Checklist. Random weekly visual checks will be conducted by a dietary manager staff are following ice scoop storage policy. 4.As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. F. 1.The spot of debris observed on the floor underneath the food rack in the dry storage area was estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2.There were no residents affected. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily Utility Staff Checklist. Random weekly visual checks will be conducted by a dietary manager to ensure routine cleaning is being completed. 4.As a means of quality	

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	In an interview on 5/15/14 at 4:30 P.M., the Director of Nursing (DoN) indicated Resident #114 was able to verbalize her pain to staff, and that the pain assessments indicated the resident had no pain. She also indicated the physician had ordered the resident pain medication as well as PRN (as needed) Tylenol for pain. On 5/16/14 at 1:45 P.M., the Staff Development Coordinator provided the pain policy, dated 1/30/12. The policy indicated, "...Through systematic approach, pain will be identified, assessed per verbal or non-verbal response, and intervention (medication and non-medication) will be initiated and re-evaluated until pain is managed to the verbal satisfaction of the resident, or (in the case of the cognitively impaired or non-verbal resident) until factors indicative of pain have subsided...." 3.1-37(a) 3.1-48-(a) DRUG THERAPY (4) each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate indications for its use. This rule was not met as evidenced by:		assurance, the weekly random visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly.	

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	Based on interview and record review, the facility failed to attempt non-medical interventions prior to the start of an anti-psychotic medication, and failed to reduce or discontinue use of a antipsychotic medication when a resident was not displaying psychotic behaviors; for 1 of 5 residents reviewed for unnecessary drugs in a sample of 6. (Resident #114) Findings include: The record review for Resident #114 was completed on 5/14/14 at 11:00 A.M. Diagnoses included, but were not limited to, dementia with behaviors, osteoarthritis, and high blood pressure. The resident was in the assisted living portion of facility until 6/8/13. She was living with her husband who was unable to care for her at that time as the resident was increasingly incontinent of urine, would become agitated when assisted with toileting and not cooperative with spouse. On 6/8/13 the resident was taken from Assisted Living apartment and moved to the Health Center. After being brought to the Heath Center, the resident displayed several behaviors. A Nurses Notes entry, dated 6/8/13,			

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	indicated the following: 7:00 A.M.--"Call from husband to report resident with increased hostility towards him and that she is back asleep but that her anger and hostilely has increased and it had been persistent which is not her norm." 8:00 A.M.-- "Husband called to report wife awake, continuing with agitation. Resident upset with husband for the way he has been treating their son and her father." 9:40 A.M.--"Resident openly agitated towards husband when she saw him at dining room table...Resident stated then that she wanted to eat breakfast and was derisive of husband as we passed him in apartment speaking vaguely of other men she should have been with and calling him a 'dumb ass' after leaving apartment." 12:00 P.M.--"New admit from assisted living...resident very agitated and irritable and was up looking and yelling for her son. Son came to visit and was agreeable in going to room with resident." 12:30 P.M.--"Physician called and was informed of resident's behaviors and an order was received for Risperdal." 1:00 P.M.--"Resident complaining of bilateral knee pain and PRN Tylenol given. Resident in halls looking for son, when son back to visit resident was in good spirits."			

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	3:30 P.M.--"Risperdal delivered and given. Resident doing well with 1:1 care." The "Social Service Documentation for MDS" (Minimum Data Set) assessment, dated 6/25/13, indicated the resident was, "...alert and oriented x 1. She has difficulty with her short term memory, as she is unable to recall questions writer was asking her...Resident is able to express needs at times, but due to inattention and word finding this can be difficult. She can also understand others, but due to cognitive impairment may misconstrue what is being said...." The assessment was marked as incomplete due to resident being unable to answer questions appropriately...Discussed diagnosis of dementia and psychotic features. Educated family member with dementia process and hallucinations..resident had become upset with staff stating that staff are "hitting on" her spouse. The family member indicated a nurse in past did hit on the spouse when his parents were younger and the resident got her fired..." A form, titled "Psychoactive Drug Monthly Flow Record," was used to track behaviors displayed by a resident. The form listed numbered behaviors, used to select the displayed behavior, and a key			

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	that instructed to enter the number of episodes, with a "C" indicating "Continuous." The forms for Resident #114 indicated the resident was receiving Risperdal 0.5 milligrams for identified behaviors of "3. Hitting." "4. Kicking," "5. Paranoia," and "12. Other--Yelling out." The resident's monthly flow records indicated the following: June 2013--Continuous yelling on the 11th, 12th, 20th, 21st. The documentation indicated no episodes of paranoia, hitting, or kicking. July 2013--one episode of "paranoia" (no specific description was documented) on the night shift, and continuous on 7/5; two episodes on 7/8; one episode on 7/17; and one episode on 7/31/13. August 2013--the behavior tracking for "12. Other" changed from "yelling out" to "refusing care." There was no documentation of any paranoia episodes. September 2013--There was no documentation of any paranoia episodes. October 2013-- There was no documentation of any paranoia episodes.			

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November 2013--There were "plus" signs documented under paranoia on 11/8, 11/9, 11/10, 11/11, 11/12, 11/16, 11/17, 11/22, 11/23, 11/27, for the day shift.

December 2013--There was a "plus" sign documented under paranoia on 12/25.

January 2014--There were "plus" signs documented under paranoia on 1/2.

February 2014--There was no documentation of any paranoid behavior.

April 2014--There was no documentation of any paranoid behavior.

The Nurses Notes in November, 2013, indicated the following behaviors:
11/8--Resident uncooperative with care and physically aggressive with care taker.
11/9--Resident cursed and screamed at CNA's during care.
11/10--Resident screaming during AM care.
11/11--Resident yelling at staff and cursing at staff, as well as crying during care.
11/12--Resident combative during shower.
11/16--Resident continues to be combative with care.
11/17--Resident combative, yelling, and

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	cussing during care. 11/22--Resident combative during care today yelling and name calling throughout care. 11/23--Resident combative and screaming during shower, yelling and cursing. 11/27--Resident combative and cursing at CNA's during care. 12/25--Resident was aggressive during care and had episode of crying before lunch. 1/2/14--Resident aggressive, yelling, and crying during care. The physician's orders recapitulation indicated the Risperdal was ordered as follows: 6/8/13- Risperidal 0.5 milligrams by mouth at bedtime for psychotic symptoms of dementia 7/8/13- Risperdal 0.75 milligrams 1 tablet by mouth at bedtime. 9/10/13- Risperdal 0.5 milligrams 1 tablet twice daily. In an interview on 5/16/14 at 2:30 P.M., LPN #2 indicated she does not usually work on this unit. She spoke to other nursing staff who told her the resident was on the Risperdal for dementia with paranoia because the resident thought that the husband was cheating on her with staff. She indicated the resident also			

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	still hits, yells and scratches at staff as well. 3.1-48(a)(4) 3.1-21 FOOD (i) The facility must do the following: (3) Store, prepare, distribute, and serve food under sanitary conditions. This rule was not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 1 facility kitchen food storage areas, food prep areas, and food equipment were maintained in a safe and sanitary manner, and followed sanitation and food safety policies and procedures. This deficiency impacted 51 of 51 residents who received food from the kitchen. Findings include: On 5/12/14 at 10:30 A.M., the kitchen tour was completed, with the Registered Dietician (RD) and the Dining Supervisor in attendance. The following was observed: One "well" pan had dried debris inside on the bottom of the pan. Another "well" pan had moisture on the inside walls,			

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	which dripped down the inside walls when picked up. In an interview at that time, the RD indicated the pans should have no debris or moisture in them. The oven had a baked, black residue inside on the bottom of the oven floor. In an interview at that time, Dietary Cook #13 indicated the oven was cleaned weekly. He believed the weekend staff were to clean it. A sanitation bucket containing a sanitizing solution was observed sitting on the food prep table. In an interview at that time, Dietary Cook #15 indicated he had changed the solution in the bucket at around 9:30 A.M. Dietary Aide #14 checked the concentration of the sanitation solution in the bucket, and indicated it was reading at 100 parts per million (ppm) She indicated the sanitation solution should be at 200 ppm. Eleven uncovered bowls of ice cream were observed on the middle shelf in one of three freezers. The RD indicated the ice cream should have been covered. An ice scoop was observed to be in the ice in the ice machine. The Dining Supervisor indicated the scoop should not be left in the ice inside of the ice machine.			

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	The floor underneath a food rack in the dry storage room was observed to have a large dark spot of debris. The Dining Supervisor indicated staff were supposed to sweep and mop daily in dry storage area, but the staff must have missed that area. The policies for the ice machine, covering of food in freezer, schedule for cleaning of ovens and the dry storage rack areas were requested at that time. On 5/12/14 at 3:30 P.M., the Registered Dietician provided the following documentation, which she indicated was all she could find: An undated document, titled "The Cooks Cleaning Schedule," was typed out indicating which days of the week which tasks were to be completed. There was no indication on the list regarding the cleaning of ovens. An undated document, titled "The Servers Extra Cleaning," indicated the dry storage area was to be organized, swept and mopped on Thursdays. An undated document, titled "Food Handling Guidelines (HACCP)," indicated "...page 5 of			

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	6...COOLING...When the food is placed in the cooling equipment (walk-in, blast chiller, etc.) : ...Loosely covered or uncovered if protected from overhead contamination..." An undated document, titled " EcoLab Sanitizer Technical Data Sheet," indicated, "...the concentration of the quat sanitizing solution must be between 200-400 ppm...." A Policy, titled "Sanitation and Infection Control Ice Handling" and dated 5/95 with a revision date of 1/14, indicated "...All food and Nutrition Services Department associates...Store the scoop in a self-draining container in an area protected from contamination. The scoop cannot be stored in the ice bin...." 3.1-21(i)(3)			
R000000	These deficiencies reflect State Residential findings cited in accordance with 410 IAC 16.2-5.	R000000	This plan of correction constitutes the written compliance for the deficiencies cited. However, submission of this plan of correction is not an admittance that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law.	

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R000090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in			

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	effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation and interview, the facility failed to post a notice with the location of the Indiana State Department of Health (ISDH) survey results. This had the potential to impact 140 of 140 residents residing in the facility. Findings include: During the initial tour on 5/12/2014 at 12:20 P.M., there was no posted notice seen in the facility's entrance lobby of the location of the State Agency's survey results. There was no posting of the availability of survey results by any elevators or halls or any place readily accessible to residents. In an interview on 5/16/2014 at 9:45 A.M., the Resident Services Director indicated the location of the survey results was not posted, but she could put some thing up like she did in the "health center."	R000090	1.The facility maintains postings of the results of the most recent annual surveys in a binder located at the receptionist desk of all licensed buildings. The surveyor was concerned that although the book was readily available she did not see a notice at the desk of the assisted living facility. Of note, notices were present in the health center. A notice was placed at the front desk of the licensed residential building the same day the surveyor inquired. 2.There were no residents adversely affected. 3.In an effort to ensure ongoing compliance, the receptionist will continue to ensure that the notice is maintained at the front desk of the licensed residential building. 4.Quality assurance will be met by the Director of Social Services verifying that the notice is being maintained to the Quality Assurance Committee quarterly.	06/02/2014

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R000187	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review the facility failed to maintain water temperatures between 100 and 120 degrees Fahrenheit. This deficiency had the potential to affect 140 of 140 residents residing in the facility. Findings include: A general observation tour of the facility was conducted on 5/14/2014 at 9:30 A.M., with Maintenance Tech # 6 in attendance. Water temperatures in several areas were checked and found to be as follows: Room 208 -- 124.5 degrees Fahrenheit (F) in the kitchenette area of the apartment. 124 degrees F from the bathroom faucet. Room 202 -- 120.6 degrees F in the kitchenette area of the apartment. 122.9 degrees F from the bathroom faucet.	R000187	1.The mixing valve at the main water heater was reset to below 120 degrees on 5/30/14. 2.The rooms listed 208, 202 and 307 were of unoccupied apartments therefore, there were no residents adversely affected. 3.Random water temperatures will be recorded on a daily basis by the housekeepers. Housekeepers will be in-serviced on 6/3/14 on logging water temps and to report any water temperature above 120 degrees to maintenance. 4.As a means of quality assurance, the housekeeping supervisor will audit that water temperatures are being recorded on a weekly basis. Audits will be reviewed quarterly with the Quality Assurance Committee on an ongoing basis.	06/03/2014

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	Room 307 -- 122.2 degrees F in the kitchenette area of the apartment. 118.6 degrees F at the bathroom faucet. The faucet in the residents's laundry area near-by, read 123.4 degrees Fahrenheit. During an observation and interview with the Director of Environmental Services on 5/14/2014 at 9:50 A.M., the water at the main water heater was found to be set in the 124 to 126 degrees Fahrenheit range. The Director of Environmental Services indicated that it had been set like that and it could be adjusted. A sign by the pipes for the water heater read 120 degrees. The Director did not comment on this sign. During an interview with the Director of Environmental Services and the Executive Housekeeper on 5/14/2014 at 9:55 A.M., they indicated that house keeping checks temperatures. A temperature monitoring log was requested at this time. On 5/16/2014 a paper titled, "Water Temps Hawthorn Hall" and dated 5/16/14 was provided. The rooms listed were as follows: room 109--118.7, room 136--119 and room 141--117. No other information was provided.			

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	A water temperature check on 5/16/2014 at 11:00 A.M., in room A 18 indicated the bathroom sink faucet's temperature was 124.5 degrees F. At exit on 5/16/2014 no additional information was provided about monitoring water temperature logs from the facility.			
R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to follow proper sanitation procedures with food preparation equipment, ensure food in the freezer was properly covered, labeled and dated, and serve food under sanitary conditions. These deficient practices had the potential to affect 110 of 110 of the residents currently being served by the assisted living kitchen at Hawthorn Hall and 30 of 30 residents being served at the special care dementia area. Findings include:	R000273	1.The Manitowac ice machines are designed with a ledge inside the bin that holds the scoop, while not allowing it to touch the ice. This is consistent with the department policy. Both pieces of equipment were uncovered as they were ready to be in use by production staff. The frozen roll dough was immediately covered and labeled with a bakers cart bag. The sheet of uncovered brownies in the dining area of the memory care area was being served at that meal. Food server #11 was immediately re-in-serviced on proper hand washing techniques. The facility considers this a rare departure of	06/13/2014

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	On 5/12/2014 at 10:30 A.M., the ice machine by the soda dispenser was observed with the door to the ice machine open and an ice scooper was lying on top of the ice. On 5/12/2014 at 4:30 P.M., the ice machine was observed with the door closed but the ice scooper was observed in with the ice. At this time the Food Service Assistant Supervisor # 9 indicated the scooper should not be in with the ice and removed it. Record review, of the facility's, "Sanitation and Infection Control Subject: Ice handling," date revised: 1/14, was completed on 5/14/14 at 12:10 P.M., and indicated the following: "Store the scoop in a self-draining container, in an area protected from contamination. The scoop cannot be stored in the ice bin, unless the container for the scoop is placed in a way that does not allow the ice scoop handle to come in contact with the ice." On 5/12/2014 at 10:40 A.M., a meat cutter and mixer were observed uncovered. At this time what were identified by Cook # 10 as "rolls" were observed, in the walk in freezer, on a rack uncovered, and unlabeled. Cook # 10 indicated, at		its hand washing policy. 2.There were no residents adversely affected 3.In an effort to ensure ongoing compliance, the ice scoop will be maintained on the ledge in the ice bin at all times. All Hawthorn Dining Services Employees will be in-serviced per policy on proper covering, labeling, and dating of products per policy. All memory care staff will be in-serviced on proper hand washing techniques. In-services to be conducted on 6/2/14, 6/3/14, 6/10/14 and 6/12/14. All dining service staff have a daily checklist to include proper covering, labeling and dating of products. Dietary managers will perform weekly visual checks to ensure that staff are following policy on proper covering, labeling, and dating of products. 4.As a means of quality assurance, the weekly visual checks conducted by the dietary supervisor will be reviewed with the Quality Assurance Committee, quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. BUILDING 00 B. WING	05/16/2014

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	the time, they were suppose to be covered and labeled. He did not know why they were uncovered like they were. Record review, of the facility's, " Food and Supply Storage Procedures," date revised: 1/14 was completed on 5/14/14 at 12:15 P.M., and indicated the following: "Frozen storage -- Store bulk materials in ... approved containers that have tight fitting lids. Label both the bin and the lid....Wrap food tightly to prevent cross contamination. Date and rotate items; first in, first out (FIFO)." On 5/13/2014 at 12:35 P.M., in the B memory care assisted living area of the facility Food Server #11 was observed serving the food on to the plates of the residents in the B area. A large sheet of brownies was observed uncovered and left as the server went to area A of the memory care area to serve. The server returned and the brownies were observed to have been placed in the oven on her return. On 5/13/14 at 12:35 P.M., Food Server #11 was observed washing her hands for 4 seconds between going from area A and area B of the memory care areas. Record review, of the facility's,			

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	"Sanitation and Infection Control. Subject: Hand Hygiene," date revised: 1/14 was completed on 5/14/14 at 12:20 P.M., and indicated the following: "Wet hands with warm water and apply a disinfectant soap, lathering up to mid-arm. Work lather into hands for 20 seconds, including areas under fingernails, between fingers, on the inside and outside of hands. Keep hands away from sides of sink. Rinse thoroughly under warm running water, allowing the water to flow from the arms, down to the fingertips...."			